

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, April 3, 2020

7:00am-8:00am

Pugh Classroom, 2nd floor, AHNCI

Zoom Meeting: <https://zoom.us/j/966171364>

Dial US: 646-558-8656

Meeting ID: 966171364

**Cases to be discussed**

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| **Case** | **De-identified patient** | **Reason** | **Presenter** |
| 1 | JM/ MRN: 634342DOB: 7/13/43 | 76 y/o male with mucosal newly diagnosed rectal melanoma.    History of prior skin cancers -- basal and squamous cell carcinomas.  He underwent PET scan 2/20 for evaluation of pulmonary nodules.  Lung lesions were all biopsied and found to be benign. PET scan showed uptake in the rectum which prompted colonoscopy done 3/16.  Rectal lesion biopsied and came back melanoma.  Patient was presented with option of APR. Discuss treatment options.   | MV |
| 2 | BS/ MRN: 721737DOB: 5/23/65 | 54 y/o male with squamous cell rectal cancer. He had a colonoscopy done on 11/212019 by Dr. Chintamaneni which revealed a polyp in the transverse colon which was removed, polyps in the sigmoid colon that were biopsied, a polyp in the sigmoid colon which was removed and a mass in the rectum that was suggestive of malignancy. His pathology was reviewed at the Multidisciplinary Colorectal Cancer Conference at AGH on 12/6/2019 and pathology stated that there were also adenomatous glandular cells in the specimen, in addition to the squamous cell carcinoma. The group’s consensus was to proceed with chemoradiation with Mitomycin C and if there is an adenomatous component, it will not respond to treatment and that he ultimately will need surgery. He started chemoradiation on 12/23/2019 and completed treatment on 2/6/ 2020. Flexible sigmoidoscopy done on 3/6/20 revealed a large ulcerated lesion occupying the distal rectum and proximal anal canal. There was noted to be some abnormal mucosa surrounding the ulcer which may represent granulation tissue or residual tumor. A biopsy was done and came back as rectal mucosa with low-grade dysplasia. His pathology was reviewed at the Multidisciplinary Colorectal Cancer Conference at AGH on 3/13/2020. Pathologist review revealed no evidence of invasive squamous cell carcinoma but still showed an adenomatous component which was no invasive. The group recommended bringing him back in 1 month for a flexible sigmoidoscopy and if anything persists he will need an APR. Radiation Oncology did order a MRI Pelvis which revealed marked interval decrease in size of bulky neoplasm from prior exam now consistent with T1/T2 circumferential mass in the mid to lower rectumDiscuss surgical options. | JM |
| 3 | JM/ MRN: 11855235DOB: 6/5/50 | 69 y/o male with hx of prostate cancer (6 years ago, treated with 44 fractions of XRT) who presents with rectal cancer. He had a colonoscopy done on 3/18/2020 and was found to have rectal mass that was biopsied and came back as colonic adenocarcinoma, moderately differentiated. A CEA was done and came back at 2.4 CT A/P revealed Diffuse thickening of the wall of the rectum with mild adjacent fat stranding and diverticulosis. MRI Pelvis done at UPMC revealed irregular thickening of the wall of the left lateral and posterior wall of the low rectum, probably extension into the left anterolateral mesorectal fat, and preserved plane between the rectum and adjacent prostate. Review scans (if disks are received in time) and discuss treatment options. | JM |
| 4 | AB/ MRN: 11845049DOB: 3/8/28 | 92 y/o female who presents with anal adenocarcinoma. She underwent a colonoscopy on 10/29/2020 by Dr. Novikov for iron deficiency anemia in Doylestown PA, and was found to have a 1 cm soft anal polyp originating in the anal canal and extending outward, a 10 mm polyp found in the anus that was pedunculated and biopsied and was a focal intramucosal adenocarcinoma in a background of high-grade dysplasia. There was a frond-like/villous fungating and infiltrative non-obstructing large mass with a mucin cap found in the cecum that was non-circumferential and involved the appendiceal orifice. It was biopsied and was a colonic mucosa with high-grade dysplasia. A frond-like/villous fungating and infiltrative non-obstructing large mass was found at the ileocecal valve that was covered in mucin, it was non-circumferential and biopsied and came back as fragments of villous adenoma. There was a frond-like/villous, fungating and infiltrative non-obstructing large polyps vs mass found in the ascending colon as well. It was tattooed and biopsied and came back as superficial fragments of adenomatous colonic epithelium with focal villous architecture. Lastly there was a 10 mm polyp found in the sigmoid colon that was pedunculated and removed with a hot snare and came back as a tubulovillous adenoma, focally extending to the cauterized specimen edge. Fex-sig with US and transanal excision was done on 1/23/2020 and revealed sigmoid diverticulosis, a 2 cm right anterior anal polyp that was removed (partial thickness) and came back as invasive adenocarcinoma, moderately differentiated, arising in an adenomatous polyp with high grade dysplasia. Carcinoma was invading the polyp stalk and lymphovascular invasion identified. Carcinoma was at least 2.0 mm from the cauterized resection margin. MSI testing came back intact.  Endorectal and endoanal ultrasound showed no evidence for lymphadenopathy or obvious muscular invasion. Last CEA on 2/5/2020 was 0.7.Patient opted for surveillance. She has since moved to Pittsburgh and saw Dr McCormick on 3/27/20. Review pathology slides and scans if available. | JM |

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Objectives

Upon completion of this activity, participants will have a better understanding of decision-making for complex colon and rectal problems and be armed with clinical pathways to improve care.

Accreditation:

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Presenters: Matthew Voth, MD/James McCormick, MD